FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045757

Facility Name: Montebello Healthcare Center

Address: 1599 Keokuk Street (Number) Hamilton (City) 62341 (Zip Code)

County: Hancock

Telephone Number: 832-467-6244 **Fax #** 932-467-6246

IDPA ID Number: 75-2080781001

Date of Initial License for Current Owners: 08-01-1986

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lee Grigsby **Telephone Number:** 832-467-6244

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Martha McDaniel
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,735	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,311	0	2,040	7,351	8
9	SNF/PED					9
10	ICF	11,256	4,187	92	15,535	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,567	4,187	2,132	22,886	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.11%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 06/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 139 and days of care provided _____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	108,033	17,639	1,546	127,218		127,218		127,218			1
2	Food Purchase		102,749		102,749		102,749		102,749			2
3	Housekeeping	63,147	9,039		72,186		72,186		72,186			3
4	Laundry	24,358	9,265		33,623		33,623		33,623			4
5	Heat and Other Utilities			97,468	97,468		97,468	27	97,495			5
6	Maintenance	22,797	34,193		56,990	(1,592)	55,398	107	55,505			6
7	Other (specify):* Garbage/Waste seepg3.1			9,927	9,927		9,927		9,927			7
8	TOTAL General Services	218,335	172,885	108,941	500,161	(1,592)	498,569	134	498,703			8
	B. Health Care and Programs											
9	Medical Director			6,969	6,969		6,969		6,969			9
10	Nursing and Medical Records	828,353	58,386	14,238	900,977		900,977	9,574	910,551			10
10a	Therapy	62,443	6,979	98,339	167,761		167,761		167,761			10a
11	Activities	36,032	3,077	2,470	41,579	6,648	48,227		48,227			11
12	Social Services	24,155	3,005		27,160		27,160		27,160			12
13	CNA Training	209		7	216		216		216			13
14	Program Transportation	21,948	33		21,981	(21,948)	33		33			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	973,140	71,480	122,023	1,166,643	(15,300)	1,151,343	9,574	1,160,917			16
	C. General Administration											
17	Administrative	69,642			69,642		69,642		69,642			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			19,527	19,527		19,527	(3,290)	16,237			20
21	Clerical & General Office Expenses	55,036	6,634	157,034	218,704		218,704	(3,431)	215,273			21
22	Employee Benefits & Payroll Taxes			331,997	331,997		331,997		331,997			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,312	18,312		18,312	7,945	26,257			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			130,459	130,459		130,459	(24,673)	105,786			26
27	Other (specify):*											27
28	TOTAL General Administration	124,678	6,634	657,329	788,641		788,641	(23,449)	765,192			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,316,153	250,999	888,293	2,455,445	(16,892)	2,438,553	(13,741)	2,424,812			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0031468 Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	3531
Infectious Waste Disposal <> Default <> Physical Plant	
Garbage Service<>Default<>Prod<>Physical Plant	6,396
Garbage Service <> Default <> Physical Plant	
	9,927

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0031468 Ending: 12/31/2005

Meals - adjustment

22,886	Days (Total Patient days)
3	Mult (3 meals a day)
68658	Sub total
0	meals to employess (reported by facility)
68658	Add Sub
102,749	Divide -Pg 3, line 2, column 2
1.50	Cost per day

1.50	Cost per day
0	mult - meal to employees
0	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

102,749	Total Food Cost (page 3,Line 2, col 3)	
0.01	Mult	
1027.49	Sub total	
18.90%	Mult	(Pvt pay div by total census)
194		
	for page 5A,	
97	= adjust for nonallowable sale tax	

Reclassification V

Page 3 Line 6

Repair & Maint <> Vehicles<>Default<>Prod<>Transport Non<>Emergency	830010000003850	(1,592)	Reclass From
(2,274 x 70% = 1,591.80)			
Page 4 line 38		1,591.80	Reclass to

Page 3 Line 14

Salaries <> Regular<>Driver<>Transport Non<>Emergency	700000750403850	(19,730)	Reclass From
	710000000003850		
Salaries Overtime/Dbl Time<>Driver<>Transport Non<>Emergency	700500750403850	(90)	Reclass From
	720001000003850		
Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport Non<>Emergen	730012000003850	(1,555)	Reclass From
Holiday Pay <> Earned Lve Taken<>Default<>Prod<>Transport Non<>Emergen	730013000003850	(573)	Reclass From
	730013750403850		
Sick Pay <> Earned Leave Taken<>Default<>Prod<>Transport Non<>Emergenc	730031000003850		
(21998 x 70% = 15399) 70% is Medical 30% is activities		(21,948)	total
Page 3 line 11		6,648	Reclass to
Page 4 line 38		15,300	Reclass to

Page 4 Line 35 Rent

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emergency	841005000003850	159	Reclass From
(-111 x 70% = -159 lease for Medical)			
Page 4 line 38		(159)	Reclass to

Facility Name & ID Number Montebello Healthcare Center #0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			6,516	6,516		6,516	3,576	10,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			53,913	53,913		53,913	(53,242)	671			33
34	Rent-Facility & Grounds			100,567	100,567		100,567	(16,722)	83,845			34
35	Rent-Equipment & Vehicles			(111)	(111)	159	48	6,551	6,599			35
36	Other (specify):* **Home Office**							8,373	8,373			36
37	**TOTAL Ownership**			160,885	160,885	159	161,044	(51,464)	109,580			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					16,733	16,733	(16,956)	(223)			38
39	Ancillary Service Centers		29,254	9,485	38,739		38,739	13,129	51,868			39
40	Barber and Beauty Shops			595	595		595		595			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		29,254	86,183	115,437	16,733	132,170	(3,827)	128,343			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,316,153	280,253	1,135,361	2,731,767		2,731,767	(69,032)	2,662,735			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0031468 **Ending:** 12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
	-

Rent-Facility & Grounds - Expenses	
Lease Expense Facility-Realty-Default-Prod	16,722
	0
	0
	16,722

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	12,056	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(228,113)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (216,057)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	163,761		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 163,761		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,296)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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Montebello Healthcare Center

ID# **0045757**

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (97)	21	1
2	Memorial / Benevolence	(487)	21	2
3	Property Tax Adjustment to Actual	(53,913)	33	3
4	Professional Liability Insurance	(24,673)	26	4
5	Depreciation Reconciliation	3,576	30	5
6	Non Allowable Advertisement	(3,844)	20	6
7	Entertainment	(16)	24	7
8	Penalities & Late Filings	0	21	8
9	Vending Receipts	(610)	21	9
10	Misc Receipts	(757)	21	10
11	Donations / Contributions	(265)	21	11
12				12
13				13
14				14
15	Legal Structure Management	(130,071)	21	15
16	Remove Rent Averaging	(16,722)	34	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37	Disallow 70% of Repairs	-1592	38	37
38	Disallow Van Driver Wages	-15364	38	38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(244,835)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center # 0045757 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	27	0	0	0	0	0	0	0	0	0	27	5
6	Maintenance	0	107	0	0	0	0	0	0	0	0	0	107	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	134	0	0	0	0	0	0	0	0	0	134	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	9,574	0	0	0	0	0	0	0	0	0	9,574	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	9,574	0	0	0	0	0	0	0	0	0	9,574	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,844)	554	0	0	0	0	0	0	0	0	0	(3,290)	20
21	Clerical & General Office Expenses	(120,231)	116,800	0	0	0	0	0	0	0	0	0	(3,431)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(16)	7,961	0	0	0	0	0	0	0	0	0	7,945	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(24,673)	0	0	0	0	0	0	0	0	0	0	(24,673)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(148,764)	125,315	0	0	0	0	0	0	0	0	0	(23,449)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(148,764)	135,023	0	0	0	0	0	0	0	0	0	(13,741)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montebello Healthcare Center # 0045757 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,576	0	0	0	0	0	0	0	0	0	0	3,576	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(53,913)	671	0	0	0	0	0	0	0	0	0	(53,242)	33
34	Rent-Facility & Grounds	(16,722)	0	0	0	0	0	0	0	0	0	0	(16,722)	34
35	Rent-Equipment & Vehicles	0	6,551	0	0	0	0	0	0	0	0	0	6,551	35
36	Other (specify):*	0	8,373	0	0	0	0	0	0	0	0	0	8,373	36
37	**TOTAL Ownership**	(67,059)	15,595	0	0	0	0	0	0	0	0	0	(51,464)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(16,956)	0	0	0	0	0	0	0	0	0	0	(16,956)	38
39	Ancillary Service Centers	0	13,129	0	0	0	0	0	0	0	0	0	13,129	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(16,956)	13,129	0	0	0	0	0	0	0	0	0	(3,827)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(232,779)	163,747	0	0	0	0	0	0	0	0	0	(69,032)	45

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	See Attachment Page 6.1		SSC Equity Holdings, I	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	SSC Equity Holdings, LLC	100.00%	$ 27	$ 27	1
2	V	6	Repair & Maintenance		SSC Equity Holdings, LLC	100.00%	107	107	2
3	V	39	Professional Services		SSC Equity Holdings, LLC	100.00%	13,129	13,129	3
4	V	20	Fees, Subscriptions, Promotions		SSC Equity Holdings, LLC	100.00%	554	554	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%	9,574	9,574	5
6	V	21	Clerical & General Office Exp		SSC Equity Holdings, LLC	100.00%	116,800	116,800	6
7	V	24	Travel & Seminar		SSC Equity Holdings, LLC	100.00%	7,961	7,961	7
8	V	26	Insurance Premium		SSC Equity Holdings, LLC	100.00%			8
9	V	36	Depreciation		SSC Equity Holdings, LLC	100.00%	8,373	8,373	9
10	V	33	Taxes - Property		SSC Equity Holdings, LLC	100.00%	671	671	10
11	V	35	Rental & Leasing		SSC Equity Holdings, LLC	100.00%	6,551	6,551	11
12	V	34	Leasse Expense		SSC Equity Holdings, LLC	100.00%			12
13	V	26	Property Insurance		SSC Equity Holdings, LLC	100.00%			13
14	Total			$			$ 163,747	$ * 163,747	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Related Illinois Nursing Homes as of 12/31/2005

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
SSC Equity Holdings, LLC	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SSC Equity Holdings, LLC
Street Address: One Ravinia Dr. Suite 1400
City / State / Zip Code: Alanta, GA 30346
Phone Number: (770) 829-5100
Fax Number: (770) 393-8054

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities		1		$ 27	$	1	$ 27	1
2	6	Repair & Maintenance		1		107		1	107	2
3	39	Professional Services		1		13,129		1	13,129	3
4	20	Fees, Subscriptions, Promotions		1		554		1	554	4
5	10	Nursing & Medical Records		1		9,574		1	9,574	5
6	21	Clerical & General Office Exp		1		116,800		1	116,800	6
7	24	Travel & Seminar		1		7,961		1	7,961	7
8	26	Insurance Premium		1				1	0	8
9	36	Depreciation		1		8,373		1	8,373	9
10	33	Taxes - Property		1		671		1	671	10
11	35	Rental & Leasing		1		6,551		1	6,551	11
12	34	Leasse Expense		1		15		1	15	12
13	26	Property Insurance		1					0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,762	$		$ 163,762	25

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Montebello Healthcare Center # 0045757 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 53,913	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 54,772	2
3. Under or (over) accrual (line 2 minus line 1).	$ 859	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 859	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	45,885	8
2001	47,957	9
2002	52,531	10
2003	53,913	11
2004	54,772	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montebello Healthcare Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0045757

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE 832-467-6244 FAX #: 832-467-6246

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-999-119	Lot B Sub (EX 2A SE Cor & 377)	$ 27,385.98	$ 27,385.98
2.	11-29-999-119	Lot B Sub (EX 2A SE Cor & 377)	$ 27,385.98	$ 27,385.98
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,771.96	$ 54,771.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	305,550	1993	$ 43,747	1
2					2
3	TOTALS	305,550		$ 43,747	3

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Interior Building Improvements			1995	8,889	444	20	444			9
10	A/C Units			1996	2,775	139	20	139		5,355	10
11	Sprinkle Guard System			1996	887	44	20	44		1,352	11
12	Sprinkler Repair			1997	2,239	112	20	112		528	12
13	Sprinkler Repair			1997	2,317	116	20	116		1,105	13
14	Carpet in Lobby			1997	1,890	95	20	95		1,006	14
15	Nurses Station			1997	2,363	118	20	118		808	15
16	A/C Systems			1997	8,325	416	20	416		1,438	16
17	Nurses Station			1997	2,613	131	20	131		3,648	17
18	A/C Systems			1997	2,969	148	20	148		1,245	18
19	Light Fixtures			1997	1,002	50	20	50		1,184	19
20	Sprinkler Repair			1997	797	40	20	40		423	20
21	2: Exterior Signs #73			1998	663	5	12	5		361	21
22	Heating, Ventilation & A/C			1998	2,643	264	10	264		577	22
23	Rplc 6: 18K BTU Heating, Ventilation & A/C #77			1998	4,070	407	10	407		2,125	23
24	2: 60 K BTU Kitchen Heating, Ventilation & A/C #78			1998	6,800	407	10	407		2,987	24
25	Phone System #72			1998	1,338	134	10	134		4,168	25
26	Nurses Station #71			1998	1,925	128	20	128		1,065	26
27	Adjustment 1998			1998		(35)			35	933	27
28	Water Heater #80 & 81 & 82			1999	3,092	309	10	309			28
29	Water Pipe Hook-up #83 & 84			1999	256	26	10	26		1,674	29
30	Generator 100 AMP XFER Switch #93			2001	5,137	257	20	257		393	30
31	3: Door Relay Instl #94			2001	912	91	10	91		1,119	31
32	2: W/G Monitor Digat Reset #95			2001	1,892	189	10	189		538	32
33	Use Tax 2: W/G Montor Digat #96			2001	8,191	819	10	819		1,545	33
34	Kohler Sink W/ Sink Rims #97			2001	592	30	20	30		3,170	34
35	Use Tax:Kohler Sink W/ Sink Rims #98			2001	34	2	20	2		116	35
36										6	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Royal 3.5 Gal Water Sver #99	2001	$ 325	$ 17	20	$ 17	$	$ 63	37
38	Use Tax: Royal 3.5 Gal Water Sver #100	2001	20	1	20	1		4	38
39	Wanderguard & Lock System Instl #102	2001	8,360	836	10	836		3,205	39
40	Air Handler & Coil Instl, Kitchen #105	2001	915	46	20	46		168	40
41	2:Push-Button & Digital reset #106	2001	822	82	10	82		301	41
42	Instl 5Ton A./C Unit Kitchen #107	2001	1,475	148	10	148		517	42
43	Instl Charge W/G System #110	2001	325	33	10	33		109	43
44	E Elec Water Heater Instl #111	2001	3,275	327	10	327		1,091	44
45									45
46	DuKane Nurse Call system #5010	2002	17,665	1,767	10	1,767		6,331	46
47	DuKane Nurse Call system # 5011	2002	6,837	684	10	684		2,393	47
48	Service Call - Old Nurse Call System # 5022	2002	863	86	10	86		1,220	48
49	Nurse Call System # 5026	2002	17,748	1,775	10	1,775		5,916	49
50	Nurse Call System -Bal Due # 5026	2002	17,748	1,775	10	1,775		5,768	50
51	Instl Nurse Call System #5027	2002	2,532	253	10	253		823	51
52									52
53	New Nurse Call Station #5030	2003	4,720	472	10	472		1,455	53
54	Breaker Instl Range Hood #5032	2003	2,135	214	10	214		677	54
55	155: Brass Dry Pendants Instl #5035	2003	1,086	43	25	43		112	55
56	Carrier -RTU NW Wing #5042	2003	7,548	755	10	755		1,887	56
57	Add sprinkler Head Stairs # 5047	2003	760	30	25	30		71	57
58	Rplc Roof UltraPlus (29% Dwn) # 5048	2003	43,215	4,322	10	4,322		10,434	58
59	CREDIT Maglock Sngl Door (#15580) #5049	2003	(691)	(69)	10	(69)		(322)	59
60	Wanderguard Instl #5050	2003	338	34	10	34		158	60
61	7: Verticle Blinds #5052	2003	840	168	5	168		406	61
62	7: Rodpocket Draps, 7 Rods # 5053	2003	869	174	5	174		406	62
63	Replc Roof #5054	2003	86,443	8,644	10	8,644		19,449	63
64	Blinds 30 Resident Rooms # 5055	2003	1,371	274	5	274		662	64
65									65
66	2:120 Gallon Water Heater	2004	7,770	583	120	583		1,166	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 309,924	$ 28,358		$ 28,393	$ 35	$ 103,339	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 309,924	$ 28,358		$ 28,393	$ 35	$ 103,339	1
2	Watermain Repair	2005	8,950	209	25	209		209	2
3	Retaining Wall - Partial Pmt	2005	6,550	136	20	136	0	136	3
4	Fire Alarm Control Panal	2005	2,531	84	10	84		84	4
5	Construct Walkway Cover	2005	5,225	145	15	145		145	5
6	Leveled Ground Around Stairway	2005	546	15	15	15		15	6
7	Fire Alarm System	2005	1,920	64	10	64		64	7
8	Instl New handrails	2005	429	10	15	10		10	8
9	Fire Alarm Control Panal	2005	926	39	10	39		39	9
10	Drywall Repairs-Water Break	2005	4,065	45	15	45		45	10
11	6 Ton 23oV, RTU	2005	27,558	919	10	919		919	11
12	Four heat Run-Duct System	2005	1,500	25	10	25		25	12
13	Rpr-Damaged Phone System	2005	1,576	53	10	53		53	13
14	Watermain Repair	2005	8,682	87	25	87		87	14
15	Retaining Wall - Partial Pmt	2005	6,359	79	20	79		79	15
16	Fire Alarm Control Panal	2005	2,404	60	10	60		60	16
17	Construct Walkway Cover	2005	5,022	84	15	84		84	17
18	Leveled Ground Around Stairway	2005	525	9	15	9		9	18
19	Fire Alarm System	2005	1,824	46	10	46		46	19
20	Instl New handrails	2005	415	7	15	7		7	20
21	Fire Alarm Control Panal	2005	872	22	10	22		22	21
22	Drywall Repairs-Water Break	2005	3,975	66	15	66		66	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 401,777	$ 30,561		$ 30,596	$ 35	$ 105,542	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 401,777	$ 30,561		$ 30,596	$ 35	$ 105,542	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 401,777	$ 30,561		$ 30,596	$ 35	$ 105,542	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 947,569	$ 43,805	$ 43,805	$		$ 297,595	71
72	Current Year Purchases	8,404	1,055	1,055	0		1,055	72
73	Fully Depreciated Assets	(513,940)						73
74								74
75	TOTALS	$ 442,033	$ 38,429	$ 38,429	$ 0		$ 298,650	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 887,557	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,989	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,025	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 36	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 404,192	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	$ 636	$ 32	$ 306	86
87	O/H Allocation 12/01/1996	1,136	57	517	87
88	O/H Allocation 08/01/1997	2,127	106	892	88
89	O/H Allocation 10/01/1997	360	18	148	89
90					90
91	TOTALS	$ 4,259	$ 213	$ 1,863	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SSC Submaster Holdings LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			01/01/2005	$ 83,846	20		3
4	Additions							4
5								5
6								6
7	TOTAL				$ 83,846 **			7

10. Effective dates of current rental agreement:
    Beginning 01/01/2005
    Ending 12/06/2024

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 11,554 Description: Ice Machines, Cooler, Dishwasher, Copiers, & Postage Machine
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Activities & Patient	1999 Ford Van E350	$ 38.55	$ 463	17
18	Transportation				18
19					19
20					20
21	TOTAL		$ 38.55	$ 463	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0031468 **Ending:** 12/31/2005

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount		Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Matress/	7295		03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	841000000002022	Concentrators	4259		
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102				03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000				03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher			03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeepin	841000000007040				03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050				03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admi	841000000008000	Mattress			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copies, Stamp machine Cable			03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plan	841000000008210				03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220				04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100				03/21/03
			11,554.00	Grand Total	

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Montebello Healthcare Center

STATE OF ILLINOIS
0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	3869	hrs	$ 20,967		$	$	3,869	$ 20,967	1
2	Licensed Speech and Language Development Therapist	10a-03	7176	hrs	8,027				7,176	8,027	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	7622	hrs	25,673				7,622	25,673	4
5	Physician Care	39		visits							5
6	Dental Care	39		visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				69,182		69,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 54,667		$	$ 69,182	18,667	$ 123,849	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center # 0045757 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 550	$	1
2	Cash-Patient Deposits	16,108		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	211,721		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	362		6
7	Other Prepaid Expenses	84,113		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 312,854	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	60,711		15
16	Equipment, at Historical Cost	8,404		16
17	Accumulated Depreciation (book methods)	(2,510)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	56,085		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 122,690	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 435,544	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (105,579)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(90,779)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(18,883)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	859		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attachment Schedule 17.1	(45,785)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (260,167)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attachment Schedule 17.1	528,679		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 528,679	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 268,512	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (704,056)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (435,544)	$	48

***(See instructions.)**

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

	OTHER CURRENT ASSETS:	AMOUNT		OTHER CURRENT LIABILITIES:	AMOUNT	
				Misc Dedctns - Employee <> Other Decductions <> Default	60	17 36-1
				Misc Dedctns - Employee <> Miscellaneous<> Default	96	
				Accruals - Insurance <> Accrue HMO Ins <> Default		
				Accruals - Insurance <> Self Funded Ins Accr <> Default	27,851	
				Accruals - Insurance <> Basic Life <> Default	354	
				Accruals - Insurance <> Lt Dsblty <> Default	41	
				Accruals - Insurance <> Dental Ins <> Default	-	
				Accruals - Insurance <> Executive Supp Life <> Default	31	
				Accruals - Insurance <> Short Term Disability <> Default	233	
				Accruals - Insurance <> Dependent Life <> Default-Dept		
				Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	4	
				Accruals - Insurance <> NES Insurance <> Default-Dept	184	
				Accruals -other Default -Dept-Suspense Allocation	16,931	
	Total	0	Difference	Total	45,785	Difference
	Reconcile with schedule XV, line 9:	0	0	Reconcile with schedule XV, line 36:	45,785	-
	OTHER NON-CURRENT ASSETS:			OTHER NON-CURRENT LIABILITIES::		
	Excess Reorganized Value <>Excess Reorg Value <> Default			I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	185,552	17 43-1
17 23-1	Other Assets <> Rfndable Deposits-Non Int Brg <> Default			Intercompany - Revolver <> Default <> Default	-795660	
				Intercompany Revolver - SSC-Default-Dept-Default-Prod	22919	
				L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	40394	
				Other Non-Current Lby <> Rent Accrual <> Default	18116	
	Total	-	Difference	Total	(528,679)	Difference
	Reconcile with schedule XV, line 23:	0	-	Reconcile with schedule XV, line 43:	(528,679)	0

Facility Name & ID Number Montebello Healthcare Center # 0045757 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,546,581	1
2	Restatements (describe):		2
3		(2,713,797)	3
4	Asset Transfer		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 832,784	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(128,728)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (128,728)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 704,056	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,213,315	1
2	Discounts and Allowances for all Levels	(1,054,777)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,158,538	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	218,787	6
7	Oxygen	375	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 219,162	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	254	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,942	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,411	19
20	Radiology and X-Ray	2,632	20
21	Other Medical Services	124,734	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 223,973	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc & General Revenue	1,367	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,367	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,603,040	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	500,161	31
32	Health Care	1,166,643	32
33	General Administration	788,641	33
	B. Capital Expense		
34	Ownership	160,886	34
	C. Ancillary Expense		
35	Special Cost Centers	39,334	35
36	Provider Participation Fee	76,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,731,768	40
41	**Income before Income Taxes (line 30 minus line 40)****	(128,728)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (128,728)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	7,248	7,278	$ 52,467	$ 7.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,486	3,501	92,627	26.46	3
4	Licensed Practical Nurses	2,196	2,205	202,227	91.71	4
5	CNAs & Orderlies	7,397	7,428	417,400	56.19	5
6	CNA Trainees					6
7	Licensed Therapist	7,072	7,109	37,810	5.32	7
8	Rehab/Therapy Aides	12,631	12,698	23,833	1.88	8
9	Activity Director	6,204	6,204	26,124	4.21	9
10	Activity Assistants	606	606	12,606	20.80	10
11	Social Service Workers	13,246	13,246	25,742	1.94	11
12	Dietician					12
13	Food Service Supervisor	40,328	40,574	19,091	0.47	13
14	Head Cook	2,025	2,037	36,729	18.03	14
15	Cook Helpers/Assistants	1,522	1,531	56,092	36.64	15
16	Dishwashers					16
17	Maintenance Workers	840	848	18,948	22.34	17
18	Housekeepers	3,345	4,136	64,606	15.62	18
19	Laundry	736	910	25,945	28.51	19
20	Administrator	330	331	72,736	219.75	20
21	Assistant Administrator					21
22	Other Administrative	704	706	29,851	42.28	22
23	Office Manager					23
24	Clerical	3,706	3,719	26,519	7.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDR Coord.Case	271	271	51,260	189.15	32
33	Other(specify) Mktg&Transpo	124	124	23,540	189.84	33
34	TOTAL (lines 1 - 33)	114,017	115,462	$ 1,316,153 *	$ 11.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	197	$ 7,617	1-3	35
36	Medical Director	48	6,900	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	197	9,574	10-7	38
39	Pharmacist Consultant	52	2,235	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		5,690	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		2,537	10a-3	43
44	Activity Consultant	45	2,470	10a-3	44
45	Social Service Consultant	55	3,005	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	594	$ 40,028		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rebecca Bliss	Administrator	100	$ 69,642
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,642

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,415
Unemployment Compensation Insurance	66,965
FICA Taxes	94,668
Employee Health Insurance	95,944
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension / Retirement	70
Insurance /Life	1,549
Other Benefits	4,386
TOTAL (agree to Schedule V, line 22, col.8)	$ 331,997

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,030
Health Care Worker Background Check	
(Indicate # of checks performed)	1,831
Dues	7,606
Other License Fees	3,398
Home Office Allocation	554
Total Advertising	4,663
Less: Public Relations Expense	( )
Non-allowable advertising	(3,844)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,238

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,595
In-State Travel	9,598
Home Office	7,961
Seminar Expense	7,119
Entertainment Expense	(16)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 26,257

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
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20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Montebello Healthcare Center # 0045757 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $7,228.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,586** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **76,103**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **None**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees